THE HANOVER
PERSONAL INJURY PROTECTION BENEFITS

CONDITIONAL ASSIGNMENT OF BENEFITS
(FOR ACCIDENTS OCCURRING ON OR AFTER 03/15/2014)

Policy Number : **Claim Number:**

Patient's Name:

I request and authorize Hanover Insurance Company (The Hanover) to pay directly to the below-named medical provider, the amount due to me under the terms of the above-referenced policy for medical care rendered to me by that medical provider and the medical staff associated with the provider's office.

_____ Date: _____
Patient's Signature or Parent/Legal Guardian

I have read the information contained in the Hanover Insurance Company informational letter concerning the Decision Point Review Plan, including Medical Services Review, Decision Point Review and precertification requirements (collectively the "Plan") and, as a condition precedent to Hanover Insurance Company acceptance of this assignment, I agree for myself, and on behalf of all medical staff associated with my office, to the following:

1) I (We) will comply with all the procedures of the Plan.
2) I (We) will initiate all Pre-certification and Decision Point Review requests as required by the Plan.
3) In the event that I (we) fail to comply with the conditions of the Plan, and such failure results in the imposition of a co-payment penalty, I (we) will hold the patient harmless for such co-payment penalty and I (we) will not seek payment from the patient for any unpaid portion of the medical services arising from such co-payment penalty.
4) I (We) will submit disputes as defined in the Plan to the Internal Dispute Resolution Process set forth therein. After final determination, submission of disputes not resolved by the Internal Dispute Resolution process to the Personal Injury Protection Dispute Resolution process set forth in N.J.A.C. 11:3-5.
5) I (We) will submit all disputes not subject to the Internal Dispute Resolution process to the Personal Injury Protection Dispute Resolution process set forth in N.J.A.C. 11:3-5.
6) I (We) will submit medical records with clinically supported findings to support the diagnosis, causal relationship to the accident and care plan.
7) I (We) will comply with a request to (i.) submit to an examination under oath, and (ii.) provide the Company with any other pertinent information/documentation that it requests.
8) I (We) agree not to pursue payment directly from the patient, with the exception of deductibles and co-payments. I (We) may revoke the assignment, and I (we) shall be entitled to pursue payment from the patient, when benefits are not payable due to lack of coverage and/or violation of a policy condition by the patient.

I (we) agree that Hanover Insurance Company Assignment of Benefits is the only valid assignment of benefits. I (we) agree that Hanover Insurance Company has the right to reject, terminate or revoke this assignment of benefits. I (we) further agree that this assignment of benefits may require Hanover Insurance Company written consent.

_____ Date: _____
Provider's Signature

Ketan Vora _____ TIN Number: 45-2741386
Provider's Name (Please Print)

Non Surgical Orthopedics of New Jersey, PC
Provider's Address: 400 Route 34, Suite A, Matawan, NJ 07747

"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties." N.J.S. 17:33A-6."